

# Clinical Section

## Acute Intestinal Obstruction

by

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No more serious catastrophe can befall a human being than acute intestinal obstruction. If not relieved by some surgical procedure such as the duodenal tube, or the Miller-Abbott tube, or by a surgical operation, the patient will surely die. Moreover, no person is exempt from such a possibility. From the newborn infant with a congenital atresia to the aged individual with an internal strangulation or obstruction from a malignant growth, no age is immune. While the condition is amenable to surgical treatment the truth is that two out of every five die. The chief cause of this prodigious mortality is *late diagnosis*. Here are the number of deaths in every 100,000 of population from the government statistics of the Province of Manitoba and the Dominion of Canada.

### DEATHS FROM INTESTINAL OBSTRUCTION

MANITOBA - - - 1936 - 1940

CANADA - - - 1936 - 1938

With Rates per 100,000 Population

Year	Manitoba		Canada	
	No.	Rate	No.	Rate
1936	39	5.5	608	5.5
1937	38	5.3	579	5.2
1938	43	5.9	609	5.4
1939	34	4.6		
1940	32	4.4		

It is not within the scope of this dissertation to go into the details of the causes and morbid conditions that bring about acute intestinal obstruction, these are well described in the various text books on the subject. Rather, we will discuss the early symptoms and signs and the early diagnosis of acute obstruction and the management of such cases, particularly as they are met with in rural practice.

### Experimental Work

There has been much experimental work done and much written as to what probable factors cause death in intestinal obstruction. Formerly it was accepted that Hartwell and Hognet proved by experiment that a toxin developed in the obstructed bowel, caused death and that saline solution (Sodium Chloride) was a direct antidote. More recent observers maintain that the condition is one of changed body chemistry. That the chlorides are diminished and the blood urea increased has been known for considerable time. To us who are more concerned with the saving of life this is at present only of academic interest. Thomas G. Orr after passing a ligature around the small bowel in dogs and administering strong sodium

chloride solution was able to keep these animals alive upwards of thirty days, whereas, those not so treated died in five or six days.

The view now held generally is that no definite toxic element exists as the result of obstruction, but that fatal outcome is due to loss of chlorides and fluids through vomiting. Sodium Chloride solution is given to replace the lost electrolytes and fluids.

### Symptoms and Signs

The late symptoms of Acute Intestinal Obstruction are well known by all of us. What we should consider more closely is the *early clinical picture* of this condition, namely, when something has occurred to prevent the normal onward flow of gas and fluid from the stomach to the rectum. We can visualize what is happening. When the peristaltic waves of the small or large intestine meet with obstruction the contraction causes pain. With the passing of the contraction the pain ceases until another peristaltic wave comes on. As the waves are intermittent so the pain is intermittent. This is spoken of as "intestinal colic" and the patient describes it as "gas pains." The colic of small bowel obstruction is located in the centre of the abdomen while that of the large bowel is located in the lower abdomen. In the former case the patient places his hand over the umbilical area, in the latter below the umbilicus. There are other abdominal colics such as "biliary colic," "renal colic," etc., from which intestinal colic must be differentiated and in the very early phase this intestinal colic may be the only symptom complained of. On two recent occasions we have on this symptom alone and with the aid of an x-ray "flat-plate" showing localized collection of air in a loop of small bowel made a diagnosis of intestinal obstruction, confirmed by operation.

The cardinal symptoms are:

1. Pain
2. Vomiting
3. Constipation.

The signs are:

1. Distension
2. Tympanites
3. Accelerated pulse rate
4. Subnormal temperature

Except for early intestinal colic they may all be regarded as late manifestations of acute intestinal obstruction. It will be noted that these symptoms are not characteristic and occur in many acute abdominal conditions.

\* Presented at the meeting of the North Western Section of the Manitoba Medical Association, Virden, Manitoba, August 13th, 1941.

1. Pain due to intestinal colic while always intermittent in the early phase, will later become constant. This may be due to pressure on the mesentery by a band or a constricting adhesion, or later from peritonitis, or rupture of the intestine, and is not referred to the back. The pain is sometimes felt in the region of the obstruction.

2. Vomiting is often an early symptom and may be reflex or due to so-called "reversed peristalsis." It should be remembered that where the obstruction is not complete, or is due to kinking, as occurs after operation, vomiting may not occur till late. In large bowel obstruction vomiting is a late symptom and the higher the obstruction the earlier vomiting occurs.

"Fecal vomiting" is rather an ambiguous term as the vomitus is from the small bowel, though foul smelling. If present, it is a late symptom and does not necessarily mean low obstruction. As A. J. Cokkinis has so wisely said, "Fecal vomiting should be dreaded as a herald of death, rather than regarded as an aid to diagnosis."

3. Constipation will be complete if the obstruction is complete. When there is no contra-indication to the giving of an enema such as a doubtful appendicitis, it is not only negative in result but confirms the diagnosis. There may be fecal matter and gas expelled from the large bowel but the result is seldom entirely satisfactory and the patient does not experience a sense of complete relief. A second enema is usually without result. If an x-ray is available an enema should not be given before plain plates have been taken in suspected intestinal obstruction.

### Examination

On examination the abdomen is found distended but distension is not an early symptom and does not develop as rapidly in intestinal obstruction as in peritonitis. Palpation is usually negative between waves of intestinal colic in the early phase, but later a knotted coil of intestine may be palpated, or when peristalsis is active contracting coils may be visible or felt through the abdominal wall.

This brief review of the symptoms and signs is only to refresh your minds in a condition which in general practice, though somewhat rare is nevertheless common enough that one should be always conscious of the possibility and that the clinical picture and local signs will vary with the duration of the attack and the section of bowel involved. It would be inexpedient to dwell on these further at this time.

Intestinal obstruction has to be differentiated from every other acute abdominal lesion by a process of elimination, and where possible by the use of laboratory tests and x-ray.

### The X-Ray as an Aid to Diagnosis

1. A flat plate of the abdomen. What may it reveal?

A plain or flat plate of the abdomen is now

easily available as most small hospitals are equipped with x-ray machines. The examination is of very little annoyance or inconvenience to the patient no matter how ill he may be. A spontaneous contrast medium, namely gas in the intestine, is already there in intestinal obstruction though other conditions may cause its presence, even retroperitoneal lesions especially obstructive or inflammatory conditions. Gas in quantity in the small bowel is seldom seen normally in a flat plate. In chronic duodenal ileus a gas shadow may be seen in that region. On the contrary the colon nearly always contains gas.

A plate should be taken in the supine position and one in the erect or left lateral, should the question of a perforation be in mind. The plate in the erect position will not only show gas distribution but fluid levels in loops of small bowel will also be seen above the obstruction. Fluid levels in small bowel are pathognomonic of small bowel obstruction and will be present in the small bowel in late large bowel obstruction. Fluid levels are seldom seen in the large bowel. A local collection of gas (seen on the plate in the supine position) may at once settle the diagnosis of obstruction and its location, as the case related below illustrates. A fluid level may be seen in the stomach but is not of diagnostic import.

The following case illustrates the value of a flat plate when in doubt.

Male, age 48 years, was seized in the night with acute abdominal pain and vomiting. He vomited twice in the first 4 hours of the attack. There was no history of preceding attacks or digestive disturbance of any kind, and no operations. The bowels had been regular up to the onset of the present illness.

The family physician had seen him and given a hypodermic of morphine which stopped the pain and vomiting. When seen by me at the hospital 20 hours after the onset of the attack the pain had returned some hours before admission. The pain was crampy in character with exacerbations but not entirely disappearing between the spasms. While the pain was diffuse from the onset it had now settled to the right side of the abdomen and there was local tenderness to the right of the umbilicus. The pain was not referred through to the back. There was some distension noted and percussion note was tympanitic throughout. Other general examinations, viz., chest, rectal and urinalysis proved negative throughout. Temperature was 99, pulse 80, and respirations 20.

Tentative diagnoses were:

1. Acute appendicitis (probably retrocecal)
2. Acute intestinal obstruction
3. Renal colic.

A flat plate of the abdomen was taken to exclude renal or ureteric stone, or the possibility of intestinal obstruction. The radiologist reported—collection of gas in a coil of small intestine in the right abdomen which he considered due to intestinal obstruction.

Emergency operation: A loop of ileum had become entangled by a string-like adhesion involving about 8 inches of the bowel and its mesentery. This was removed and the circulation to the part being intact the bowel was returned into the abdomen. The appendix was normal and was not disturbed.

Three days later distension becoming alarming and not relieved by enemata, Pituitrin, gastric lavage, and other medical treatment—a jejunostomy was performed with complete relief to the patient.

As already mentioned if an x-ray is available a diagnostic enema should not be given before the plates are taken as the picture would be distorted and fluid levels may show in the colon thus leading to error in interpretation of the plates. Subsequently a simple enema may be given for diagnostic or therapeutic reasons.

When obstruction is low in the small bowel and distension is considerable, the small bowel tends to arrange itself in transverse folds across the abdomen—the characteristic “step-ladder” appearance. A plain plate also differentiates between small and large bowel obstruction and furthermore may show the exact segment of either involved.

Volvulus of the small bowel will give a picture much the same as a strangulated loop. Volvulus of caecum or right colon and of the sigmoid or pelvic colon give large gas shadows in the right or left abdomen.

## 2. X-ray with contrast medium.

Barium per oram should never be given in intestinal obstruction. Barium given in impending or partial obstruction because of the barium solution becoming inspissated in the intestine will most likely precipitate a complete obstruction and thus bring about a condition we are so anxious to avoid. In suspected obstruction from a growth or other causes in the colon, should the plain plate be inconclusive or show the colon distended with gas and the sigmoidoscope did not reveal an obstruction it were well to give a barium oil enema. This is a most valuable aid not only in diagnosing the presence of obstruction but its exact location in the large bowel can also be seen. Stereoplates are a great advantage in determining whether an abdominal excision or an abdomino-perineal resection should be the procedure of choice and whether the preliminary drainage should be from the caecum, transverse or left colon, necessitating a caecostomy, transverse colostomy or sigmoidostomy.

When obstruction in the large bowel is intermittent or relieved by an enema it is suggestive of a recurring intussusception. A “double contrast enema” may reveal an intestinal polyp as the cause of the intussusception.

Two cases of recurring intussusception with intermittent obstruction came under my care. One was ileocaecal in a boy of twelve years. His appendix had been removed elsewhere without relief of symptoms. X-ray with simple barium enema showed a filling defect at ileocaecal region. Fixation of the lower ileum to the posterior parietal peritoneum gave complete and permanent relief.

The second case was one of intermittent large bowel obstruction always relieved by an enema. At the time of obstruction a mass could be palpated in the mid abdomen which disappeared when relief was obtained. Barium enema and x-ray demonstrated a filling defect in the transverse colon. A section of the colon with a sessile polyp was removed and the continuity of the bowel re-established by end to end suture. Pathological report of specimen was—Carcinoma grade I.

## Treatment

The treatment of acute mechanical intestinal obstruction seen within the first twelve hours of the onset of the attack is immediate laparotomy, relieving the obstruction and closing the abdomen forthwith. Patients in this favorable stage and under favorable conditions for immediate action are only occasionally seen. They are the simplest cases met with and should, and actually are, rewarded by being practically 100% cures. This dictum does not apply to post-operative obstruction which is discussed later and pyloric obstruction does not belong to this category.

## An Illustrative Case

A patient was seen in the middle of the night with acute abdominal pain and vomiting. The pain which began in the evening preceding, was intermittent in character, was in the mid abdomen and the patient placed his hand over the umbilicus when asked to locate the pain. The abdomen was flat and nothing definite could be demonstrated on physical examination, including a digital rectal. His pulse rate was 110 and temperature registered 97.5 (note the pulse temperature ratio). His appendix had been removed some years before and a drainage tube inserted.

On removal to hospital an enema was given with no result for faeces and very little gas expelled. Immediate operation showed a loop of ileum tightly constricted by a fine band of adhesion about the diameter of coarse twine. Needless to say recovery in this case was uneventful.

## Comments

One was reasonably sure of the diagnosis with such symptoms as those presented by the patient. Moreover there was a potential cause for obstruction, namely appendicitis operation with drainage and the inevitable formation of adhesions either from the inflammation necessitating the drainage or those produced by the presence of the tube itself.

Unfortunately few patients with intestinal obstruction are seen in this favorable phase. When distension has occurred as is the inevitable result of delay, relief from this becomes the prime objective. Three methods are available:

1. The Duodenal Tube
2. The Miller-Abbott tube
3. A Jejunostomy.

1. The duodenal tube is always available and should be inserted at once where nausea or vomiting is present, nor do I know of any contraindication to its use. In intestinal obstruction it is indispensable and is preliminary to any treatment that may follow. With gastric and duodenal suction by the Wangansteen method, much can be accomplished but it has its limitations. If a Miller-Abbott tube is available it is vastly more efficient. The duodenal tube is always at hand—the Miller-Abbott tube may not be.

2. The procedure before the advent of the Miller-Abbott tube was a jejunostomy. In the last few years operative drainage of the small bowel has rarely in my experience, been necessary.

The Miller-Abbott tube requires perseverance and some experience in its use. It is often tedious and difficult to get the tube to pass the pylorus



but the reward obtained when it has been successfully passed into the distended small bowel is marvellous. When the distension is relieved but the obstructive cause persists, laparotomy, which must be done forthwith, is simplified.

3. If, for any reason, the tube should fail to enter the intestine a jejunostomy must be resorted to at once.

While examination and diagnosis are under consideration and intestinal decompression under way, time need not be lost; replacement therapy should proceed simultaneously. One thousand c.c. of saline solution and 5% glucose can be administered slowly (intravenously) and is useful in any acute abdominal catastrophe. Ringers solution if prepared, which more nearly represents the blood serum, may be better but we have found the above efficient.

### The Technique of Jejunostomy

Under local anaesthesia a small left subcostal incision is made. Muscles split and not cut. The first distended loop of small bowel is drawn gently out and if possible by passing the index finger along the mesentery its direction found. I doubt the wisdom of turning the bowel about if thought to be directed the wrong way if the following technique is used. A purse string is inserted and the ends left long, the bowel punctured and a large size Pesser catheter inserted and purse string tied. A second purse string is inserted for added safety. The great omentum is placed between the bowel and parietal peritoneum. The ends of the purse strings are tied over small gauze pads placed on the skin after the wound is closed. This holds the bowel against the abdominal wall but not stitched to it. After the catheter is removed there is scarcely any leakage and the wound quickly heals.

I have opened the abdomen in one patient two years later and the bowel had freed itself from the abdominal wall and there was not even a sign of adhesion either between the great omentum and the abdominal wall or the small intestine.

Some years ago I discussed with a colleague of mine, who had a small hospital in a rural town, acute intestinal obstruction and how a jejunostomy was a life saving measure when distension was present. Only a few weeks passed when my friend had in his hospital a farm hand with acute obstruction. The doctor did a jejunostomy which gave immediate relief. The obstruction persisting, a week later I resected a constricted segment of the ileum. This was reported by a pathologist as due to tuberculous ulceration. This is mentioned, en passant, simply to illustrate what may be done in an emergency. The duodenal tube was not in vogue at the time and the Miller-Abbott tube did not exist.

In the past I have operated on cases where distension was much greater than was thought to be from the clinical examination. In such an event the distended small intestine pushes itself through the opening onto the abdomen. It would be im-

possible to return these distended coils into the abdomen unless they were first decompressed. What might seem a perplexing predicament for the surgeon is really an advantage for the patient provided the surgeon is forearmed. From the beginning of my surgical experience I have never undertaken an operation for acute intestinal obstruction without having a rubber tube about the size of a rectal tube with two lateral openings close to the end eighteen inches long and connected with a glass tube to another rubber tube (not of smaller calibre) and long enough to reach a basin under the operating table. By applying a purse-string of No. 0 chromic gut six or eight inches proximal to the obstruction (I have applied it below when the obstruction was in view and easily relieved) puncturing the bowel in the center of the purse-string and quickly inserting the end of the tube into the distended bowel draining off its gas and foul smelling fluid. I have frequently slid the whole small intestine over a little more than a foot of rubber tubing, the bowel collapsing as fast as it could be passed over the tube. The syphonage was so great that one had to work rapidly to prevent the bowel wall being sucked against the end of the tube, hence the advantage of two lateral openings near the end. (A glass tube as advocated by Moynihan is more easily manipulated than the rubber tube). Of course all precautions to prevent soiling must be taken such as turning the patient somewhat toward the operator, drawing the distended loop well out over a pad that can be quickly changed and by compressing the bowel above and below the opening till the tube is inserted. Most soiling is at the moment of inserting the tube into the bowel which must be done quickly. Once syphonage is established there is no more leakage at the opening. Any soiling should be sponged away with saline solution.

When the tube is removed the pursestring is tied and reinforced if deemed necessary. A small detached omental graft is finally applied. The obstruction is removed and the intestines are now easily returned into the abdomen. The edges of the wound are sponged with saline solution. Rubber gloves should be changed before suturing the incision. It is advisable to use figure of S silkworm gut sutures tied very loosely over rubber tubing to reinforce the wound. A small rubber drain is inserted at each end down to the aponeurosis or if much soiling, down to the closed peritoneum.

Only rarely now has one to resort to such measures as emptying the bowel over a tube, as decompression by the Miller-Abbott method should always be preliminary to opening the abdomen. When, however, strangulation of a loop is imminent or has occurred, too much time must not be lost in trying to pass the tube which usually takes three or four hours before it has successfully reached the distended loops. Then one may be forced to act and be confronted with resection of an area of gangrenous bowel as well as doing decompression from the open abdomen.

### Post-Operative Obstruction

Post-operative intestinal obstruction should be considered in a class by itself.

Obstruction occurring a few days after an abdominal operation is very unfortunate for the patient and most disturbing to the surgeon. However the outlook is not entirely dark.

The obstructing cause is a kinking of the small bowel brought about by adhesions. Post-operative distension initiates the trouble and as distension increases, kinking of the bowel becomes more and more aggravated until stoppage is complete.

The first impulse of the surgeon is to re-open the abdomen and relieve the obstruction. That is the very last thing to be thought of. The patient has had a major operation from which, but for this complication, he is making a favorable recovery. To open again the wound and explore for the trouble would be more likely to increase than to relieve the complication. In the past two years I have been called to operate on two such cases. The Miller-Abbott tube had not been tried in either. The immediate and important thing to be done is to *relieve the distension*. There are two ways in which this can be accomplished, first by the Miller-

Abbott tube and second by a jejunostomy as already described in the treatment of a late case. Both cases mentioned above were relieved by the Miller-Abbott tube and nothing further was necessary as the kinked bowel again took on normal function.

### Resume

1. Intestinal obstruction is a most fatal disease.
2. The significance of acute abdominal pain and early vomiting is not fully realized.
3. Delayed action is the cause of the present prodigious mortality.
4. Immediate replacement of fluids and chlorides lost by vomiting and supporting sugar given by vein are the first steps of treatment.
5. Decompression of distension by the Miller-Abbott tube is preliminary to operative relief, of small bowel obstruction, which is thereby simplified.
6. Distension may be greater than judged from the clinical picture in a relatively early or border line case. Therefore a suitable sterilized tube for emptying the bowel should always be on hand for such an eventuality before proceeding to operate. This of course should have been anticipated and relieved by the Miller-Abbott tube.
7. Post-operative obstruction is invariably due to kinking and not strangulation and is relieved by decompression by the Miller-Abbott tube.

## Abortions

### *A Review of 326 Cases from the Public Gynecology Wards of the Winnipeg General Hospital*

by D. B. STEWART, M.D.

In the recent maternity survey conducted over the province, abortion was found to be the leading cause of maternal death. 22.5% of all deaths resulting from pregnancy were due to this cause. In comparison with this alarming figure it was considered of interest to present a report on a series of cases treated on the public gynecological wards of the Winnipeg General Hospital. This series of 326 cases comprises all cases of abortion admitted to the service over the five-year period 1936-1940 inclusive. During this time there were no deaths, although many severely infected cases found their way to this department. This result, though admittedly in part due to good fortune, is considered to be ample justification of the conservative methods of treatment advocated by members of the gynecological staff.

As a broad classification, the cases were grouped as follows:

Missed abortion .....	5 cases	( 1.5%)
Therapeutic abortion	13 "	( 4.0%)
Threatened abortion...	28 "	( 8.6%)
Inevitable abortion.....	280 "	(85.9%)

These will be considered in order.

**Missed Abortion:** There were only five cases in this group, all of whom responded satisfactorily to treatment with oxytocic drugs.

**Therapeutic Abortion:** The indications for inducing abortion in these thirteen cases were varied, mitral stenosis and tuberculosis heading the list with four each, and one case each of fibroids,

unbalanceable diabetes, pyonephrosis, and toxemia. The method employed necessarily depended on the stage of the pregnancy and the nature of the indication. Hysterotomy and sterilization was employed in four cases, dilatation and curettage in three, bougies in three, subtotal hysterectomy in two, and medical induction in one.

**Threatened Abortion:** In 28 cases pregnancy was successfully carried on and the patient left the hospital free of symptoms. How many of these actually went to the stage of viability it is impossible to say, as many of them were lost track of. It is interesting to note that nineteen of these cases complained at some time of both abdominal pain and vaginal bleeding, while five complained of bleeding only and four of pain only. It would seem that the presence of both symptoms in a moderate degree is not conclusive proof of inevitable abortion. The treatment used was bed rest until some days after all symptoms had subsided, with moderate sedation when necessary. One case required vaginal packing. Wheat germ oil and A.P.L. were given in two cases.

**Inevitable Abortion:** This is the largest group, with 280 cases, and the most important from the standpoint of treatment. It includes those cases in which the abortion was completed before admission to hospital as well as the incomplete abortions. It was found that the stage to which an abortion had proceeded before admission had little bearing on its management, and that a much more reliable guide to treatment and prognosis was the



severity of the infection as determined by the temperature. Accordingly they have been grouped as high-grade and low-grade febrile, and afebrile cases. Those with a temperature over  $101^{\circ}$  on two or more successive days are considered high-grade. The proportions are as follows:

Febrile — high-grade	18.2%
— low-grade	52.5%
Afebrile	29.3%

Eighty-two cases, or nearly 30%, gave a history of interference, and of course this is not the whole truth. In sixty-eight there had been direct interference per vaginam, including douches and various medications applied locally. Slippery elm still appears to be the favorite. In the other fourteen cases the interference was allegedly purely medical, as by quinine or ergot, purgatives or enemata, etc. That this may have been understatement is suggested by the fact that several of these cases were febrile.

**The Treatment of Inevitable Abortions:** All cases in which there was any possibility of carrying on the pregnancy were classed, *pro tem.*, as threatened abortions and treated as such. Should they become inevitable, the "hands-off" policy was still followed as far as possible, intra-uterine manipulation being reduced to a minimum and used only in carefully selected cases.

Oxytocic drugs are the mainstay of the conservative treatment of abortion. Quinine, ergot preparations and pituitrin have all been used, singly or in combination. In the past two years the tendency has been to use the fluid extract of ergot less, and the ergot alkaloids such as ergometrine more. The use of pituitary extract too has increased, and pituitrin and ergometrine are often used in combination. It is interesting to note that oxytocics have been the only treatment in 48% of the cases.

In cases of excessive hemorrhage which did not respond to oxytocics, packing was used. By this is meant, of course, packing into the fornices, rarely into the cervical canal, and never into the uterine cavity. Quite frequently when the cervix was exposed placental tissue could be removed from the external os. Packing was done in sixty-four cases, or 23%. In eleven of these the procedure was done more than once. In the past two years the number of packings dropped off sharply. This may possibly be correlated with the increased use of pituitrin and the ergot alkaloids, though the number of cases is too small to be conclusive.

The use of blood transfusion has increased somewhat, partly because it is beginning to be used more to hasten convalescence rather than as a purely emergency measure.

As in all other branches of medicine, the sulphonamide drugs have gained wide use in the treatment of infection due to abortion. Not used at all in 1936, last year sulphonamides were given in 25% of all cases of inevitable abortion. Again it is too early to arrive at any conclusion, but the increased use of these drugs coincides suggestively

with a noticeable decrease in the number of post-abort complications.

The only operative treatment used in this series was dilatation and curettage, and this was reduced to a minimum, being used in only thirty-eight cases or 13.6%. In almost all instances the indications and prerequisites for operation could be summarized as follows:

1. A history of recent abortion.
2. Persistent bleeding which either did not stop or else recurred after a thorough trial of conservative treatment.
3. Absence of infection, as shown by a normal temperature for several days before operation.
4. An adequate haemoglobin level, brought up if necessary before operation by iron, and occasionally transfusion.

Of the thirty-eight cases in which curettage was necessary, all but four had aborted within the first trimester. The interval from the abortion to the time of operation averaged seven weeks; the pre-operative stay in hospital averaged eighteen days; they had been afebrile for an average of nine days. Two cases only were operated upon while they still had a slight temperature. The post-operative hospital stay averaged about ten days. Placental or decidual tissue was found in the scrapings in thirty-six of the thirty-eight cases. There were no post-operative complications.

**Residual Complications:** Twenty-five cases, or 9% of the whole group, had residual complications which could be considered definitely due to the abortion. In addition to those summarized in the table below there were ten doubtful cases.

Pelvic cellulitis	8 cases
Salpingitis	6 cases
Thrombophlebitis	4 cases
Septicaemia	2 cases
Pelvic abscess	2 cases
Bartholinitis	1 case
Metastatic synovitis	1 case
G. C. cervicitis	1 case

The incidence of complications has dropped somewhat during the five years, and as would be expected they were more frequent in the high-grade temperature group.

Criticism has been leveled at the conservative treatment of abortions because of the longer hospital stay involved. But it is the feeling in this department that any measure is justified which will reduce the morbidity, complications, and mortality. Early instrumental interference, while sometimes successful, often stirs up infection, increases the chance of complications, and all too often ends in a fatality.

### Honour for Dr. Mathers

Dean A. T. Mathers addressed the Royal College of Physicians and Surgeons of Canada on "Psychoneurosis in War-Time" at the recent meeting in Ottawa. He was elected President of the College for the forthcoming year. This is a great honour for Dr. Mathers and for the province he represents.

## Winnipeg Medical Society

Dr. J. C. Hossack, *President*.  
 Dr. C. B. Stewart, *Vice-President*.  
 Dr. H. F. Cameron, *Secretary*.  
 Dr. David Swartz, *Treasurer*.  
 Dr. A. E. Deacon, *Trustee*.  
 Dr. Eyjolfur Johnson, *Trustee*.  
 Dr. A. Leishman, *Trustee*.

### MEETINGS

Third Friday each month.

Next Meeting — November 21st.

Note — Meetings start exactly at 8.15 p.m.

### NOTICE BOARD

The Winnipeg Medical Society is a part of the Manitoba Medical Association, and as such, may properly claim a portion of the Bulletin. The Editor saw things the same way and now the Society has a printed page of its own.

One function of this page is to keep all members au fait with what is going on, even if it should be impossible for them to take active part. Another function is to give early notice of what is planned in the way of programme. It is not always possible to carry out these plans. Circumstances may compel alterations.

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The October meeting might aptly be described as a "howling" success. The speakers were in a gay mood and proved that science does not have to be serious. Doctor A. F. Menzies, Professor Savage and Professor Wardle entertained as well as instructed what was certainly one of the largest audiences, if not the largest ever attracted to a regular meeting of the Society.

Their topic, "Animal Diseases in Man" brought home to those present the intimate relationship between the greater and lesser creations in the matter of disease. Doctor Menzies, out of a large experience, spoke with man as the centre of his theme. Professor Savage dealt with the role played by the larger animals and made some gloomy prognostications as to the future incidence of encephalitis. Professor Wardle concerned himself with the lowly, repulsive unnecessary worms — a logical enough ending, however, to any programme which deals with man and life.

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For November, we contemplate a presentation dealing with the ovarian and allied hormones. The curse of a plethora of trade names here reaches its abominable height. What to give, when and how to give it are puzzling questions to many, and furthermore, there is no branch of practice from which their use is excluded, so there is something in this for everyone.

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Doctor Sigurdson tells me that recently he met Surgeon Lieutenant Commander C. W. MacCharles who complained to him of the difficulty naval men had in getting professional reading matter. I have heard a similar complaint from officers in the Air Force. Those of you who have copies of journals, etc., to spare are asked to get in touch with Doctor

Allison who will see that the journals are sent to those who need them.

I also understand that the members of the Society in England are disappointed that we have not sent them letters, gifts or in any way remembered them. Doctor C. B. Stewart is going to remedy this as far as he can. He is finding out what they would most like to get, and will arrange to send those things as a gift from us. We further propose to send them periodically a report of what is going on here in medical circles.

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The Nazis realize that the blitzing of babies loses half its kick, if the hospitals are well equipped to treat them. Hence the hospitals are also blitzed. We want to help these hospitals which sadly lack equipment and therefore we have established a depot in each of the city hospitals, where you may leave surplus instruments, etc. We want to have this Society lead in the quantity of supplies obtained. What you do not need may be a godsend Overseas. We are ready to take everything you can give, and if it is too big to carry, we will send a truck after it. Doctors from out of town who wish to help can send their parcels to us and so save the additional expense of sending them to Toronto.

\* \* \*

An invitation to attend the meetings of the Society is hereby extended to out of town practitioners. Arrangements are underway to inform all medical officers in the Service that they are heartily welcome. The same invitation is also extended to the city doctors, who still are not members, with this proviso, however, that they apply for membership.

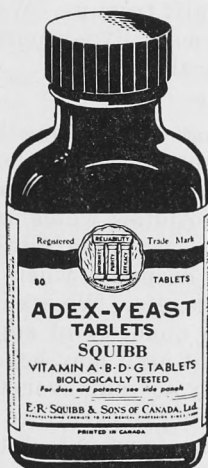
At the last meeting of the Society, the following were received as members:

Lander, J. J.	Jones, E. A., Jr.
Lerner, A. I.	Blakie, N. H.
Zeavin, S.	Quong, T. L.
Howden, J.	Stephens, G. M.
L'Heureux, P.	Stephenson, Earl
Marlatt, Helen	Hague, O. G.
Malcomson, H. M.	Black, Wm. A.
Tass, David	Porter, J. A.
Letienne, Rene	Wood, W. J.
Stuart, F. G.	Downey, J. L.

There are still a number of fees outstanding. Doctor Swartz will be on hand with his receipt book at each meeting.

J. C. HOSSACK.

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\* Strauss, M.B., J.A.M.A. 110:953, 1938

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## Editorials and Association Notes

### The Manitoba Medical Review

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*Editorial or other opinion expressed in this Review is not necessarily  
 sanctioned by the Manitoba Medical Association*

Reading should be divided into light amusement and serious books. Too much of either causes a weariness of the spirit. According to the patient's taste the light material will consist of fiction magazines, detective stories, wild west stories, love stories, humorous stories or novels. If an adequate library is not available cheap paper-covered books such as the Penguin volumes may be purchased. Most of the first hundred titles issued in this series are worth reading. Serious books comprise biography, history and travel. A few suggested titles are Maurois' "Disraeli," Macaulay's "History of England," volume one, Prescott's "Conquest of Peru" and "Conquest of Mexico," and Horn's "Trader Horn."

### OBITUARY

#### Dr. Stanley G. Herbert

No event in recent years has more deeply stirred the medical profession in Winnipeg than the tragic death on September 28th of Dr. Stanley G. Herbert. He and his wife had driven over about midnight to see his mother who had been reported to be ill at her home on Cornish street near Misericordia hospital. As the following day was Sunday no undue alarm was felt over his absence from home until about seven in the evening when it was discovered that the doctor, his father, mother and nephew were dead, and his wife unconscious from gas poisoning. Mrs. Herbert was removed to Misericordia Hospital, but despite unremitting care, she died three days later. A joint funeral of the five victims was held from Westminster Church on October 2nd. At a coroner's inquest it was established that gas seeping from a broken main had been responsible for the tragedy.

At the time of death, Dr. Herbert, at the age of 47, was treasurer of the Manitoba Division of the Canadian Medical Association, member of the surgical staff of St. Boniface Hospital, and a recently created Fellow of the American College of Surgeons. He had been Chief of Staff of St. Boniface Hospital for two years and treasurer of the Winnipeg Medical Society. After graduating from the Faculty of Medicine, University of Manitoba in 1919 he practised in Winnipeg first with the late Dr. Gerhard Hiebert, and then with Dr. Dan. Hossack.

In his youth he was an excellent hockey player with the Varsity team and with the Senior Winnipeggers in 1913 and 1914. Later he was keenly interested in golf and curling, despite the demands of a heavy practice.

His bright personality, his kindness and his professional ability made him a general favorite and his loss is widely mourned.

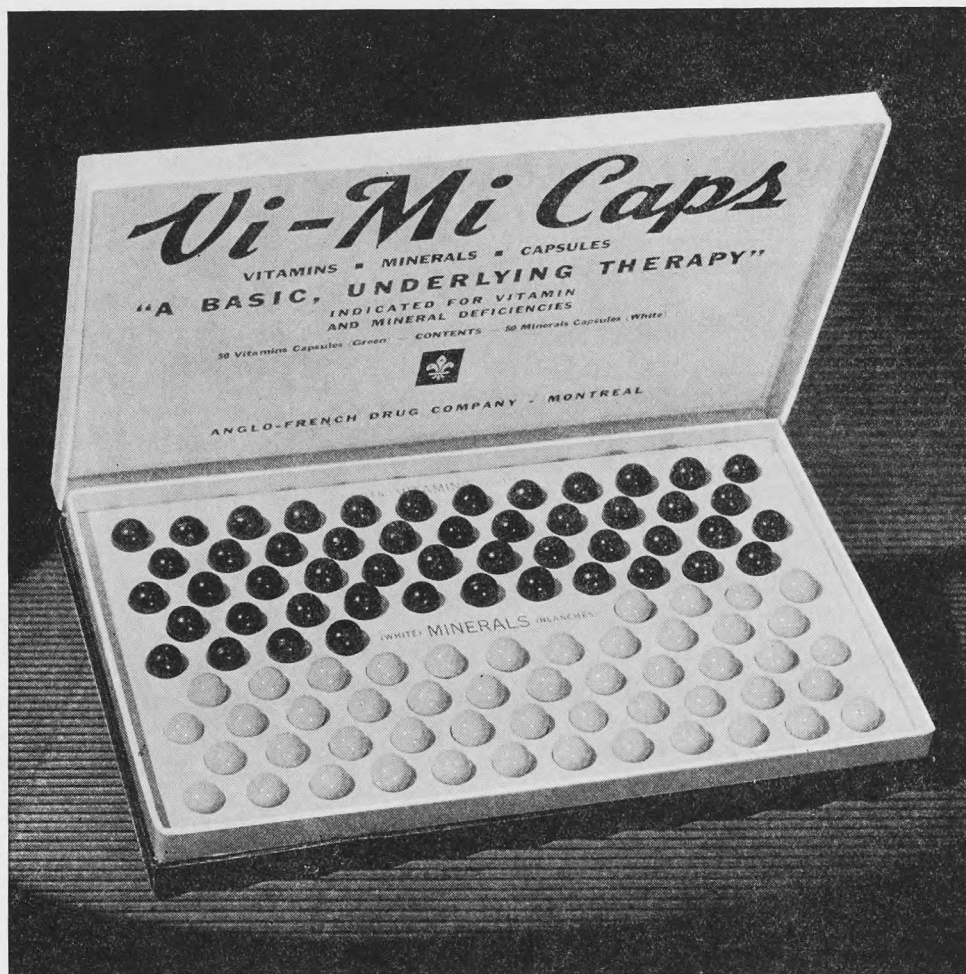
He is survived by four daughters, to whom our deepest sympathy is extended.

### Work and Amusement for the Bedridden

In the case of patients who are willing to accept advice, the doctor can make a long period of bed rest more bearable by suggesting suitable mental work and amusement.

Patients who already have a trade or profession can plan a course of technical reading in their chosen fields. Those too young to have an occupation can carry on with school work or take a correspondence course. For example, all patients entering the Manitoba Sanatorium are offered correspondence courses in Automobile Operation and Repair, Advertising, Commercial Art, Cookery, Dressmaking, Refrigeration, Photography, Printing, Radio Servicing, Bookkeeping, Short-hand, Typewriting, etc., etc. The technical branch of the Manitoba Department of Education arranges for these courses and pays half the cost.

Pastimes such as fancy work, letter-writing, crossword puzzles and games will occupy some time, but the main amusements for the bedridden are reading and the radio. The best way to listen to the radio is to make a list of desired programs from the newspaper each day and to set a little alarm clock to ring just when the wanted program is due.



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## Personal Notes and Social News

Conducted by Gerda Fremming, M.D.

Captain John M. Kilgour, R.C.A.M.C., and Mrs. Kilgour are receiving congratulations on the birth of a daughter. Mrs. Kilgour was formerly Miss Betty Joyce.

♡ ♡ ♡

Dr. Robert F. M. Myers, R.C.A.M.C., and Miss Joan Margaret Elliott, daughter of Dr. and Mrs. W. J. Elliott of Brandon, were married on September 27th in St. Paul's United church, Brandon. Dr. and Mrs. Myers left by motor for the East and will reside in Ottawa.

♡ ♡ ♡

Dr. and Mrs. William Ormond have left for Nelson, B.C., where they will make their home.

♡ ♡ ♡

Mr. and Mrs. Hugh Neave, Higher Disley, Cheshire, England, are receiving congratulations on the birth of a daughter, October 4th. Mrs. Neave was Dr. Shirley Taylor, '35.

♡ ♡ ♡

Dr. D. G. Revell has joined His Majesty's Forces.

♡ ♡ ♡

Dr. Joseph S. Holowinski was recently married to Miss Helene Rosemary Julius. The honeymoon is being spent in Eastern Canada.

♡ ♡ ♡

Dr. and Mrs. Brock Fahrni are enjoying a short leave in Vancouver. Dr. Fahrni is with His Majesty's Forces.

♡ ♡ ♡

Dr. and Mrs. Daniel Blake have arrived in Winnipeg from Philadelphia where they have been living for three years. They will only be in the city a short time. Dr. Blake is the son of the late Dr. M. R. Blake.

♡ ♡ ♡

Dr. Margaret Anderson (Greta Connor '38) of Regina, spent a two weeks' vacation in Winnipeg, the guest of her parents.

♡ ♡ ♡

The Association wishes to extend its deepest sympathy to Dr. and Mrs. W. W. Musgrove and family in the loss of their son, Roy, who was accidentally killed on Tuesday, October 14th, when he fell down a stope in the Hudson Bay Mining and Smelting Co. mine at Flin Flon, and also to Dr. James M. Morrow of Prince Albert, Sask., in the loss of his wife on Oct. 18th.

♡ ♡ ♡

Lieut. Fred Walton, R.C.A.M.C., and Mrs. Walton have arrived recently from England and are the guests of Dr. Walton's parents, Dr. and Mrs. F. C. A. Walton.

Major George Ryan, who has been overseas with the 5th Canadian General Hospital spent a short leave in Winnipeg.

♡ ♡ ♡

Dr. and Mrs. Harold Hutchison of Bridgetown, Barbados, B.W.I., have arrived in Winnipeg. Dr. Hutchison is the son of Dr. J. N. Hutchison of Winnipeg.

♡ ♡ ♡

Dr. John C. Rennie, son of Mrs. Rennie and the late Dr. W. H. Rennie, of Portage la Prairie, was married on October 10 in Portage to Miss Margaret Isobel Souter, daughter of Mr. and Mrs. George Souter. Dr. and Mrs. Rennie left on a wedding trip to the Pacific Coast.

♡ ♡ ♡

Dr. George Wallace Elliott, aged 77, retired Canadian Government Immigration physician and early settler in Manitoba, died at his home on Lulu Island, near Vancouver, on October 22. He was born in Ireland, and first settled in Manitoba as a farmer. Later, he joined the Winnipeg police force, where he served for seven years until he graduated from Manitoba Medical College in 1897. He went to the Yukon in the Gold Rush of 1898 and practiced in the north until 1903, when he was made Canadian Government Immigration Medical Inspector. He went first to Ellis Island and later to Portland, Me. He retired in 1925.

♡ ♡ ♡

The *Review* is always glad to receive items of a personal or social nature for this page; however, as the *Review* goes to press a week in advance of publication date, contributions must be in by the 20th of the month preceding date of issue.

### Winnipeg Authors

In the London *Lancet* of August 23 there appeared an article by Lt. Col. C. H. A. Walton, M.D., Majors H. M. Graham, M.D., and L. P. Lansdown, M.D. Lt. Col. Walton and Major Lansdown are Winnipeggers on the staff of No. 5 Canadian General Hospital, Taplow, England. The article described three cases of acute ulcerative stomatitis characterized by severe toxæmia and extreme prostration. The organism found in all three was a Gram positive encapsulated diplococcus, morphologically identical with the pneumococcus but with cultural differences.

The patients did not respond to adequate sulphyridine therapy, but transfusions of pooled whole blood seemed to act as a specific. It is suggested by the authors that infections of the mouth with organisms other than Vincent's may be associated with a deficiency in nicotinic acid.





## *A Stitch in Time*

As winter approaches, the availability of Vitamins A and D decreases and the need for them increases. Therefore . . . in order that the stores built up during the summer months may be maintained . . . it is advisable to begin administration of these vitamins early, rather than to wait until the need for them is clinically demonstrated. Small doses in time may well obviate the necessity of much larger doses later on.

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## Department of Health and Public Welfare

We are publishing herewith the fourth of the essays prepared by the medical students before taking the final examination in Preventive Medicine at the Faculty of Medicine of the University of Manitoba last year. The one for this month is written by Doctor N. L. Auckland, on the subject "A Provincial Venereal Disease Programme," and reads as follows:

### "A Provincial Venereal Disease Programme"

"It is my plan in this article to outline, as briefly and clearly as possible, the organization, methods and problems of a Provincial programme of Venereal Disease Control. In doing so, I propose to deal with the subject matter under the following headings:—

- "(1) General Aspects of the Problem
- "(2) Legislation
- "(3) Organization
- "(4) The Private Practitioner and Venereal Disease Control.

#### General Aspects

"The Venereal Diseases constitute one of the major public health problems of today. In Canada, treatment of this problem is, as yet, in its infancy. The scanty reliable statistical data which is available, has not shown any clearly defined diminishing trend. Indeed, available figures would suggest an incidence considerably above that of Great Britain and the Scandinavian countries where exceptional results have been obtained in control programmes. It is not difficult to understand why venereal disease still constitutes such a major health problem when one considers how complex are the factors relating to acquisition and transmission—how rooted it is in defects and inadequacies of our Social and Economic Life and what barriers are raised by prudery, ignorance and defeatism on the part of the public.

"Because of these intensely human elements, the Venereal Diseases stand alone among the infectious diseases, and special considerations must be made in dealing with them. Thus, besides an adequate programme for prophylaxis, diagnosis and treatment, it is important to think of social reform and social hygiene. No Venereal Disease programme is complete unless there is a close co-operation between the medical and social units of a community.

#### Legislation

"Without comprehensive legislation the hands of the Public Health Department are tied. It is suggested that the following points be dealt with:

- "(1) Definition of Venereal Disease.
- "(2) Compulsory examination and treatment of prisoners.
- "(3) Medical health officers be given authority to require any suspected person to be examined by a qualified physician.
- "(4) Suppression of quacks, treatment by the unqualified and advertisement of articles for treatment or prevention.
- "(5) Prosecution of any infective person who does any act liable to spread the infection.
- "(6) Protection of patients under treatment, i.e., reports, names, etc., are confidential and not open to the public.
- "(7) Pre-marital and pre-natal examinations.
- "(8) Free silver nitrate to hospitals for control of gonorrheal ophthalmia.
- "(9) Suppression of prostitution—this is a very

important problem. Fundamental to the effective control of any communicable disease are the measures directed toward finding the source of the infection and making it as inaccessible as possible. Commercialized prostitution is probably the most prolific source of venereal infections and laws to stamp it out must be definite and adequate. Having these laws, it then should be the aim in every Venereal Disease programme, to induce a most vigorous enforcement of them. It has been shown here in Vancouver that the effective enforcement of the sections of the Criminal Code directed against commercialized prostitution has reduced the incidence of venereal disease in the male population of the City. (1).

- "(10) Free treatment of all patients with venereal disease. (See below).

"These are by no means all that should be dealt with, but would form a basis for any progressive venereal disease programme.

#### Organization

"Under the Provincial Department of Health there is usually a sub-department, such as a Department of Disease Prevention, which includes venereal disease.

"The working unit of this is the 'Government Clinic' which is really the source of the active campaign. This clinic is free. Grants to the Provinces by the Dominion Government commenced in 1920 and now free treatment is in effect in every Province in Canada.

"In providing free treatment, the object is two-fold:

- "(a) Cure of existing cases and
- "(b) Prevention of new ones.

"It is generally felt that the sooner cases are brought under treatment, the fewer fresh cases will arise. Treatment, therefore, is available to all classes, the aims of the clinic being:

- "1. To treat promptly and effectively all persons with venereal disease.
- "2. To place a specialist within reach of all.
- "3. To make continued treatment and ultimate cure (in the majority of cases) possible.
- "4. To reach the greatest number possible as early as possible.
- "5. To disseminate information concerning nature and prevalence of venereal disease.

The organization of the clinic itself may be as follows:

"**Director:**—A qualified physician and a specialist in Venereal Diseases. He should be chosen not only for his knowledge, but for his enthusiasm and ability. Upon his initiative largely depends the success or failure of the clinic.

"**Medical Consultants:**—also qualified physicians who work at the clinic either full or part-time. They diagnose and supervise treatment of all patients.

"**Technicians:**—trained in methods of laboratory diagnosis and technique of treatment. In most clinics, trained orderlies or special male technicians take care of male patients and nurses or female technicians take care of female patients.

1. The Canadian Public Health Journal—October, 1940.  
"Commercialized Prostitution and Venereal Disease Control," Donald H. Williams, M.D. — Director, Division of Venereal Disease Control; B.C. Board of Health.



"Good laboratory facilities are essential—these include darkfield microscope, good stains for smears, and a good standard of investigation for gonorrhœa, i.e., smears and cultures, etc. Treatment as outlined by the consultant is carried out by the above technicians and records of all treatment are carefully kept.

"Beds must be available for the more severely or acutely ill. Facilities for use of malarial therapy are necessary.

"**Department of Records and Statistics**—is invaluable in any clinic. In this way the progress and success of the clinic can be watched, errors and weaknesses picked up and the whole programme strengthened and rounded out.

"**Social Service Department** is also an essential to the Venereal Disease clinic. The job of these workers is most complex and difficult. They are the ones who are usually entrusted with finding new cases, contacts, sources, etc. Here the human element comes to the fore again, so that the workers must be chosen for their special aptitude in this direction. They must be tactful as well as persistent. New cases must be persuaded to come to the clinic for treatment, and having once started, to come regularly. Recalcitrant patients must be written, re-written, interviewed and argued into returning. Compulsion should only be the last resort.

"Thus through a competent Social Service the Clinic is able to give prompt and adequate treatment to each new case as it is found, and to each contact or source as it is unearthed, and thereby materially reduce the incidence of venereal disease.

"Also through the efforts of the Social Service branch of the clinic, patients are educated as to the characteristics of these diseases, their incidence, mode of transmission, diagnosis and chance of cure. In syphilis especially, it must be emphasized in the layman's mind, that in early cases the percentage of cures is considerably higher than in late cases.

"An attempt must also be made to remove the stigma usually attached to venereal disease. This can be done mainly by public education. The methods of putting this across are many—personal contact, motion pictures, records, public talks and pamphlets.

"**Public Health Nurses** should all receive an adequate training in venereal diseases; and the best and most logical place for this is the clinic where they can study the diseases as they are diagnosed, treated and cured. Here they learn the problems that are presented by the patient and they get a better insight that will later be of great value to them in their work. No public health nurse is fully equipped to do her best work unless she knows enough about these diseases to suspect their presence when it should be suspected and knows enough to be able to steer the infected to those services the community has to offer.

"Therefore, every Venereal Disease programme should make some provision for the instruction and training of these nurses in venereal disease.

#### **The Private Practitioner**

"Last, but by no means least, we must consider the place of the private physician with regard to venereal disease control.

"Provincial action alone cannot hope to wipe out venereal disease. The patient raises barriers both natural and artificial which often no one but his own doctor can break through. However, the relatively small number of doctors cannot treat all patients with venereal disease. The answer to this is the tax-supported clinic as mentioned above. This, plus providing anti-luetic drugs free, facilities for Darkfield and serological examinations at a Provincial laboratory, and possibly courses of instruction in venereal diseases, is the duty of the state to the physician.

"On the other hand, the duty of the physician to

the state must be primarily, a co-operative attitude. His care of venereal disease patients must be as good as that of the clinic, or not at all. He should be especially prompt in reporting all cases, recalcitrant patients, sources and contacts. He should instruct each patient about the disease, explaining in lay terms, complications without adequate treatment, chance for recovery, complications in marriage, etc.

"The private doctor is especially important with regard to venereal disease in pregnant women. He should do a serological test on all pre-natal cases as soon as they present themselves. Inconclusive reports should be repeated. If the results are positive, husband and family, contacts and sources should be diligently sought. Treatment should be instituted immediately, and carried through to cure. The patient should be informed as to the nature of her ailment and instructed re her infectiousness. Periodic examination of the child should be routine and treatment started on positive diagnosis.

#### **Summary**

- "1. Of all infectious diseases, venereal disease presents the most complex and difficult problems.
- "2. A plan for Venereal Disease Control must be adequate and effective.
- "3. Laws must be all-embracing, and must be stringently enforced.
- "4. Treatment must be available to all.
- "5. An effort must be made to remove taboos and educate the public.
- "6. A close co-operation must exist between private physician and the Provincial Health Department."

### **COMMUNICABLE DISEASE REPORT**

**August 13th - September 9th**

**Anterior Poliomyelitis:** Total 402—Winnipeg 92, St. Boniface 26, Unorganized 19, Strathcona 12, St. Clements 11, Transcona 11, Portage la Prairie Rural 10, St. James 10, Brandon 8, Rosedale 8, Tache 8, Norfolk North 7, St. Vital 7, Ste. Anne 6, Brokenhead 5, Coldwell 5, Kildonan East 5, Morden Town 5, Turtle Mountain 5, Westbourne 5, Woodlands 5, Bifrost 4, Birtle Rural 4, Gladstone 4, Grey 4, Kildonan West 4, Lakeview 4, Rhineland 4, Rockwood 4, Rosser 4, Saskatchewan 4, Springfield 4, Stonewall 4, Victoria 4, DeSalaberry 3, Lansdowne 3, Macdonald 3, Montcalm 3, McCreary 3, Portage la Prairie City 3, Ritchot 3, Stanley 3, St. Paul East 3, Teulon 3, Assiniboia 2, Cartier 2, Elton 2, Fort Garry 2, Franklin 2, Langford 2, Morris Rural 2, Riverside 2, Selkirk Town 2, Siglunes 2, Ste. Rose Rural 2, Woodworth 2, Argyle 1, Charleswood 1, Daly 1, Dauphin Town 1, Ellice 1, Emerson 1, Gimli Village 1, Glenella 1, Hamiota Rural 1, Hanover 1, Lorne 1, Miniota 1, Ochre River 1, Pembina 1, Pilot Mound Village 1, Piney 1, St. Andrews 1, St. Laurent 1, Thompson 1, Tuxedo 1, Virden Town 1, Winnipeg Beach 1 (Late Reported: St. Laurent 1, Unorganized 3).

**Encephalitis:** Total 394—Winnipeg 88, Brandon 18, St. Boniface 17, Stanley 16, Transcona 9, Turtle Mountain 8, Argyle 7, Portage la Prairie Rural 7, St. James 7, Whitewater 7, Unorganized 6, Arthur 5, Cypress South 5, DeSalaberry 5, Norfolk North 5, Pipestone 5, Rhineland 5, Springfield 5, Victoria 5, Brenda 4, Cameron 4, Franklin 4, Hamiota Rural 4, Harrison 4, Lorne 4, Portage la Prairie City 4, Riverside 4, Rockwood 4, Stonewall 4, St. Vital 4, Westbourne 4, Edward 3, Grey 3, Hamiota Village 3, Neepawa 3, Oakland 3, Souris 3, Shellmouth 3, Sifton 3, Woodworth 3, Assiniboia 2, Birtle Rural 2, Cartier 2, Gladstone 2, Hanover 2, Kildonan East 2, Macdonald 2, Miniota 2, Minnedosa 2, Napinka 2, Norfolk South 2, Roblin Rural 2, Rosser 2, Siglunes 2, Strathcona 2, St. Andrews 2, Ste. Anne 2, St.



Laurent 2, St. Paul East 2, Ste. Rose Rural 2, Ste. Rose du Lac Town 2, Tache 2, Tuxedo 2, Winchester 2, Woodlands 2, Albert 1, Archie 1, Beausejour 1, Bifrost 1, Blanshard 1, Brooklands 1, Charleswood 1, Cypress North 1, Daly 1, Ellice 1, Fort Garry 1, Gilbert Plains Rural 1, Kildonan North 1, Kildonan Old 1, Kildonan West 1, Killarney Town 1, La Broquerie 1, Lakeview 1, Louise 1, Melita 1, Minto 1, Mossey River 1, Pembina 1, Pilot Mound Village 1, Piney 1, Plum Coulee 1, Ritchot 1, Rivers Town 1, Roland 1, Strathclair 1, St. Clements 1, Thompson 1, Virden Town 1, Wallace 1, Whitehead 1, Whitemouth 1 (Late Reported: Brandon 1, Gimli 1, St. Clements 1).

**Tuberculosis:** Total 60—Unorganized 10, Winnipeg 7, Brandon 5, Blanshard 2, Norfolk North 2, Portage la Prairie City 2, Selkirk Town 2, St. Boniface 2, Assiniboia 1, Brokenhead 1, Brooklands 1, Cartier 1, Dauphin Rural 1, Dufferin 1, Ellice 1, Flin Flon 1, Fort Garry 1, Kildonan East 1, Lac du Bonnet 1, Lakeview 1, Macdonald 1, Morris Rural 1, Mossey River 1, McCreary 1, Ritchot 1, Rosedale 1, Saskatchewan 1, Stanley 1, Ste. Anne 1, St. James 1, St. Laurent 1, The Pas 1, Transcona 1, Turtle Mountain 1, Westbourne 1, Winchester 1.

**Mumps:** Total 41—The Pas 9, Tuxedo 8, St. James 7, Winnipeg 5, Brandon 3, Flin Flon 1, Portage la Prairie City 1, Transcona 1 (Late Reported: Brandon 6).

**Chickenpox:** Total 26—Winnipeg 9, Brandon 6, Emerson 2, Selkirk Town 2, Hanover 1, Pipestone 1, Saskatchewan 1, Stonewall 1, St. Vital 1 (Late Reported: St. Boniface 2).

**Measles:** Total 18—Winnipeg 4, Argyle 2, Brandon 2, Hamiota Village 1, Portage la Prairie City 1, Woodlea 1, Victoria 1 (Late Reported: Brandon 5, St. Boniface 1).

**Whooping Cough:** Total 17—Dauphin Town 5, Rockwood 4, Unorganized 3, Winnipeg 3, Brandon 2.

**Scarlet Fever:** Total 15—Winnipeg 5, Kildonan East 2, Brokenhead 1, Hamiota Rural 1, Macdonald 1, Ochre River 1, Portage la Prairie Rural 1, St. Andrews 1 (Late Reported: St. Laurent 2).

**Influenza:** Total 13—Brandon 4, Hamiota Rural 2, Blanshard 1, Elton 1, Hamiota Village 1, Norfolk North 1, Sifton 1 (Late Reported: Unorganized 1, St. Francois Xavier 1).

**Pneumonia Lobar:** Total 9—Brandon 3, Sifton 1, La Broquerie 1 (Late Reported: Mossey River 1, St. James 1, Assiniboia 1, St. Boniface 1).

**Diphtheria:** Total 5—Winnipeg 4, Cartier 1.

**Meningococcal Meningitis:** Total 3—Fort Garry 2, Tuxedo 1.

**Erysipelas:** Total 3—Brenda 1, Winnipeg 1, Woodlands 1.

**Puerperal Fever:** Total 1—Lakeview 1.

**Undulant Fever:** Total 1—Brokenhead 1.

**German Measles:** Total 1—Brandon 1.

**Venereal Disease:** Total 127—Gonorrhœa 88, Syphilis 39.

## DEATHS FROM COMMUNICABLE DISEASE

August, 1941

**RURAL**—Cancer 35, Lethargic Encephalitis 20, Tuberculosis 18, Pneumonia Lobar 2, Pneumonia (other forms) 4, Poliomyelitis 3, Influenza 1, Syphilis 1, other deaths under one year 23, other deaths over one year 187, Stillbirths 15. Total 309.

**URBAN**—Cancer 35, Lethargic Encephalitis 30, Poliomyelitis 9, Tuberculosis 8, Pneumonia Lobar 4,

Pneumonia (other forms) 3, Syphilis 2, Diphtheria 1, Influenza 1, Parotitis, acute 1, Sporotrichosis 1, other deaths under one year 14, other deaths over one year 157, Stillbirths 17. Total 283.

**INDIANS**—Tuberculosis 9, Influenza 1, other deaths under one year 9, other deaths over one year 4, Stillbirths 1. Total 24.

Disease	Manitoba Sept. 10-Oct. 7	Ontario Sept. 7-Oct. 4	Saskatchewan Sept. 7-Oct. 4	Minnesota Sept. 7-Oct. 4	North Dakota Sept. 7-Oct. 4
Anterior Poliomyelitis	79	34	18	79	2
Meningococcal Meningitis	1	26	1		
Chickenpox	71	252	15	71	
Diphtheria	11	11	5	11	7
Erysipelas	3	6	3	1	
Influenza	4	44	15	3	3
Encephalitis Epidemic	20		128	48	78
Measles	12	103	41	35	30
German Measles	2	34	22		
Mumps	51	169	54		
Lobar Pneumonia	3	27		31	11
Scarlet Fever	49	367	53	79	11
Septic Sore Throat	2	39			
Smallpox				1	
Trachoma			1		
Tuberculosis	20	185	40	84	55
Typhoid Fever	4	22	44	4	2
Paratyphoid Fever	1	2	83		
Undulant Fever		6	2		
Whooping Cough	2	417	23	238	65

Note: In looking over the records from the adjoining Provinces and States for the four-week period ending October 4th and 7th it is to be noted that the encephalitis epidemic has pretty well ceased excepting for "late reported" cases. A few cases of poliomyelitis are still being reported but these are mostly late ones. Ontario has twenty-six cases of meningococcal meningitis, also a fair amount of scarlet fever and septic sore throat.

Saskatchewan is having an epidemic of typhoid and para-typhoid fever—127 cases in the four-week period. These are mostly in the area around North Battleford and north of there. Regina has a few cases and there are odd scattered cases. We have had one case which came in from Saskatchewan. The four Manitoba cases are all in one family in the Municipality of DeSalaberry.

## If they could talk, Council Seals would say:

"When you see one of us on a package of medicine or food, it means first of all that the manufacturer thought enough of the product to be willing to have it and his claims carefully examined by a board of critical, unbiased experts. . . . We're glad to tell you that this product was examined, that the manufacturer was willing to listen to criticisms and suggestions the Council made, that he signified his willingness to restrict his advertising claims to *proved* ones, and that he will keep the Council informed of any intended changes in product or claims. . . . There may be other similar products as good as this one, but when you see us on a package, *you know*. Why guess, or why take someone's self-interested word? If the product is everything the manufacturer claims, why should he hesitate to submit it to the Council, for acceptance? Mead Johnson Products are Council-Accepted."

—Adv.

## A Dietary Prescription » » » » » »

# *FRESH, HEALTHFUL* **APPLES!**

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The contents of an apple read like a medical prescription—Levulose, Sucrose and Dextrose sugars; pectin and hemicellulose—good sources of Uronic acid; iron, calcium and phosphorus; vitamins A, B and C with a trace of G; Tannic, Malic and Citric acids, and water.

In Europe, apples have been used therapeutically for over two centuries. More recent research in Canada and the United States has confirmed many of the European findings and has, in addition, shown many new uses and values in the apple.

The physical and nervous strains of these war years make national health even more a matter of supreme importance, and medicinally and therapeutically, the Canadian apple has the elements necessary for playing a major roll in the maintenance of Canada's war-time health.

From an economic viewpoint, the use of the Canadian apple takes on an added importance in that no foreign exchange need be spent for it that could be spent for essential, imported armaments.

The twenty-five hundred apple growers in the interior valleys of British Columbia, by whom this advertisement is published, are interested in the further nutritional and medical knowledge and use of the Canadian apple.

Your comments on this would be much appreciated. Address your letters to—

**BRITISH COLUMBIA FRUIT BOARD**  
**KELOWNA - - B.C.**